

CHAPTER 5

EVALUATION AND MANAGEMENT DOCUMENTATION



The following evaluation and management (E/M) documentation topics are discussed in this chapter:

- Guidelines for residents and teaching physicians; and
- Evaluation and management background.

Also included are the following reference materials:

- Reference I - *1995 Documentation Guidelines for Evaluation and Management Services*; and
- Reference II - *1997 Documentation Guidelines for Evaluation and Management Services*.

Guidelines for Residents and Teaching Physicians

Both residents and teaching physicians may document physician services in the patient's medical record. The documentation must be dated and contain a legible signature or identity and may be:

- Dictated and transcribed;
- Typed;
- Hand-written; or
- Computer-generated.

The attending physician who bills Medicare for E/M services in the teaching setting must, at a minimum, personally document:

- His or her participation in the management of the patient; and
- That he or she performed the service or was physically present during the critical or key portion(s) of the service performed by the resident (the resident's certification that the attending physician was present is not sufficient).

Students may also document services in the patient's medical record. The teaching physician may refer only to a student's E/M documentation that is related to a review of systems (ROS) and/or past, family, and/or social history (PFSH). If the medical student documents E/M services, the teaching physician must verify and repeat documentation of the physical examination and medical decision making activities of the service.

The following guidelines apply to the documentation required for the three major categories of E/M services:

Initial Hospital Care, Emergency Department Visits, Office Visits for New Patients, Office Consultations, and Hospital Consultations

For initial hospital care, department visits, office visits for new patients, office consultations, and hospital consultations, the teaching physician must enter a personal notation that demonstrates the appropriate level of service that the patient requires and documents his or her participation in the following three key components:

- History;
- Examination; and
- Medical decision making.

If the teaching physician repeats key elements of the service components that the resident previously obtained and documented, his or her note may be brief, summarize comments that relate to the resident's entry, and confirm or revise the following key elements:

- Relevant history of present illness (HPI) and prior diagnostic tests;
- Major finding(s) of the physical examination;
- Assessment, clinical impression, or diagnosis; and
- Plan of care.

Subsequent Hospital Care and Office Visits for Established Patients

For subsequent hospital care and office visits for established patients, the teaching physician must enter a personal notation that highlights two of the three following key components:

- History;
- Physical examination; and
- Medical decision making.

For follow-up visits for established patients, the initial hospital care, emergency department visits, office visits for new patients, office consultations, and hospital consultations guidelines described above must be followed.

Exception for Evaluation and Management Services Furnished in Certain Primary Care Centers

Medicare may grant a primary care exception within a Graduate Medical Education (GME) Program in which the teaching physician is paid for certain E/M services the resident performs when the teaching physician is not present. The primary care exception applies to the following lower and mid-level E/M services and the initial preventive physical examination (IPPE) (also known as the “Welcome to Medicare Physical”):

New Patient	Established Patient
CPT Code 99201®	CPT Code 99211
CPT Code 99202	CPT Code 99212
CPT Code 99203	CPT Code 99213

Effective January 1, 2005, the following code for the IPPE is included under the primary exception:

- Healthcare Common Procedure Coding System code G3044:
Initial Preventive Physical Examination: face-to-face visit, services limited to new beneficiary during the first six months of Medicare enrollment.

The range of services furnished by residents include the following:

- Acute care for undifferentiated problems or chronic care for ongoing conditions including chronic mental illness;
- Coordination of care furnished by other providers; and
- Comprehensive care not limited by organ system or diagnosis.

The types of residency programs most likely to qualify for the primary care exception include family practice, general internal medicine, geriatric medicine, pediatrics, and obstetrics/gynecology. Certain GME programs in psychiatry may qualify in special situations, such as when the program furnishes comprehensive care for chronically mentally ill patients.

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A center must attest in writing that all of the following conditions are met for a particular residency program:

- The services must be furnished in a center located in the outpatient department of a hospital or another ambulatory care entity in which the time spent by residents in patient care activities is included in determining direct GME payments to a teaching hospital.
- Any resident furnishing the service without the presence of a teaching physician must have completed more than six months of an approved residency program.
- The teaching physician in whose name the payment is sought must not supervise more than four residents at any given time and must direct the care from such proximity as to constitute immediate availability. The teaching physician must:
 - Have no other responsibilities, including the supervision of other personnel, at the time of the service for which payment is sought
 - Assume management responsibility for those patients seen by the residents
 - Ensure that the services furnished are appropriate
 - Review the patient's medical history, physical examination, diagnosis, and record of tests and therapies with each resident during or immediately after each visit and
 - Document the extent of his or her own participation in the review and direction of the services furnished to each patient
- The patients seen must be an identifiable group of individuals who consider the center to be the continuing source of their health care and in which services are furnished by residents under the medical direction of teaching physicians. The residents must generally follow the same group of patients throughout the course of their residency program, but there is no requirement that teaching physicians remain the same over any period of time.

Evaluation and Management Background

Medicare pays physicians based on diagnostic and procedure codes that are derived from medical documentation. E/M documentation is the pathway that translates a physician's patient care work into the claims and reimbursement mechanism. This pathway's accuracy is critical in:

- Ensuring that physicians are paid correctly for their work;
- Supporting the correct E/M code level; and
- Providing the validation required for medical review.

E/M includes some or all of the following elements:

- Documenting history. Each type of history includes some or all of the following elements:
 - Chief complaint
 - A concise statement that describes the symptom, problem, condition, diagnosis, or reason for the patient encounter
 - Usually stated in the patient's own words
 - HPI
 - Brief, which includes 1 to 3 elements
 - Extended, which includes at least 4 elements OR the status of at least 3 chronic or inactive conditions
 - Conducting a ROS, which is an inventory of body systems obtained through a series of questions that seek to identify signs and symptoms that the patient may be experiencing or has experienced. The three types of ROS are:
 - Problem pertinent, which inquires about the system directly related to the problem identified in the HPI
 - Extended, which inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems (2 – 9)
 - Complete, which inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional body systems (minimum of 10) and
 - Examining relevant PFSH which consists of a review of the following three areas:
 - Experiences with illnesses, operations, injuries, and treatments
 - Medical events, diseases, and hereditary conditions that may place the patient at risk
 - Social history that includes age appropriate review of past and current activities

The two types of PFSH are:

- Pertinent, which is a review of the history areas directly related to the problem(s) identified in the HPI
 - Complete, which is a review of 2 or all 3 of the history areas, depending upon the category of E/M service
- Performing a physical examination. The extent of the examination performed is based upon:
 - Clinical judgment
 - The patient's history and
 - The nature of the presenting problem(s)

The two types of examinations are:

- General multi-system
 - Involves the examination of 1 or more organ systems or body areas
 - Each body area or organ system contains 2 or more examination elements and
- Single organ system
 - Involves a more extensive examination of a specific organ system

Both general multi-system and single organ system examinations can be one of the following types:

- Problem focused
 - A limited examination of the affected body area or organ system
 - Expanded problem focused
 - A limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s)
 - Detailed
 - An extended examination of the affected body areas(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s) or
 - Comprehensive
 - A general multi-system examination OR complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s)
- Considering all identified diagnostic and therapeutic factors when making decisions about the patient's illness and treatment. Medical decision making can be one of the following types:
 - Straightforward
 - Low complexity
 - Moderate complexity or
 - High complexity

The complexity of medical decision making is determined by considering the following factors:

- The number of possible diagnoses and/or the number of management options that must be considered
 - The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed and
 - The risk of significant complications, morbidity and/or mortality as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options
- Documenting an encounter dominated by counseling and/or coordination of care (more than 50 percent of the total time) in a face-to-face physician/patient encounter:
 - Time is the key or controlling factor to qualify for a particular level of E/M service and
 - Includes time spent with the patient and/or the patient and his or her family in the office or other outpatient setting, on the floor of a hospital, or a nursing facility

Providers may use either the *1995 Documentation Guidelines for Evaluation and Management Services* or the *1997 Documentation Guidelines for Evaluation and Management Services* (see Reference I and Reference II below). Medicare Contractors must conduct reviews using both the 1995 and the 1997 guidelines and apply the guidelines that are most advantageous to the provider.

To find additional information about E/M documentation, visit www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp#TopOfPage and see the Medicare Claims Processing Manual (Pub. 100-4) at www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage on the CMS website.

